COVID-19 Vaccination Rates in Minorities and Rural Populations

ACOI Healthcare Heroes

Medicine 3.0 at #ACOI2021

Achieving Personal Wellbeing
inside:
ACOI info August 2021

Letter From Our President 3
Continuing the Fight Against COVID
Read

ACOI 2021 Convention 4
Explaining “Medicine 3.0” Read

Insights from the Committee on Health Equity and Inclusion in Medicine 5
COVID-19 Vaccination Rates in Minorities and Rual Populations Read

ACOI Healthcare Heroes 6-7
Dr. Leonard R. Hock is Working Every Day in the “Belly of the Beast” and Relentlessly Educating to Halt Vaccine Hesitancy Read

Insights from the Wellness Task Force 8
Achieving Personal Wellbeing in Your Life Read

Government Relations 9-10
• Washington in Brief
• ACOI Joins in Opposition to VA National Standards of Practice
• ... and more! Read

Coding Corner 11-12
Additional Highlights from the Proposed 2022 Medicare Physician Fee Schedule Read

Hints from Hermann 13
Incorporating OMM into your practice Read

Online Learning Center 14
Available 24/7 for your CME needs Read

Job Board 15
Open positions seeking applicants Read

75th Anniversary Circle Members 16
Thank you for your support! Read

2020-2021 OFFICERS
Michael A. Adornetto, DO, MBA, FACOI
President
Michael.Adornetto@UHhospitals.org
Robert L. DiGiovanni, DO, FACOI
President-Elect
robert.digiovanni27@gmail.com
Joanne Kaiser-Smith, DO, FACOI
Secretary-Treasurer
kaiserjo@rowan.edu
Samuel K. Snyder, DO, FACOI
Immediate Past President
snydersam@att.net
Annette T. Carron, DO, FACOI
Past President
carronannette@gmail.com

BOAD of DIRECTORS
Damon L. Baker, DO, FACOI
damonbaker@okstate.edu
Robert A. Cain, DO, FACOI
cain@aacom.org
Watson Ducatel, DO, MPH, FACOI
drwd@healthybodiesmdc.com
Susan M. Enright, DO, FACOI
susan.enright@hc.msu.edu
Charlene A. LePane, DO, FACOI
clepane@hotmail.com
Robert T. Hasty, DO, FACOI
rhasty@me.com
C. Clark Milton, DO, FACOI
cmlilton@wheelinghospital.org
Laura Rosch, DO, FACOI
LRosch@kcumb.edu
Amila Vasoya, DO, FACOI
vasoya.909@gmail.com
Valentina Stevanovich Lassalle, DO
Resident Rep
vslassalle@gmail.com

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Continuing the Fight Against COVID

We find ourselves in the midst of the fourth wave of COVID-19 battling primarily the Delta variant as summer comes to a close. As we reverse some masking policies and continue to see improved acceptance of the COVID-19 vaccine, we continue to encounter some pockets of resistance to immunization and some of these are entrenched in distrust of the pharmaceutical industry and the organizations that support them.

Most ACOI Presidents have not followed the path I traveled through internal medicine pediatrics training, which allowed me to view the world of vaccination somewhat differently. Although adult medicine employs vaccination strategies to improve the health of adult patients and for population health, childhood vaccination strategies have focused on protecting the most vulnerable patients, our children. Even in my relatively short career, I have been able to see many changes in disease management due to vaccinating against some of the most invasive diseases which provide significant protection to all children, and reassurances to parents that they can sleep a little better knowing their child will not suffer from debilitating illness.

During my internship year I recall a young child passing through the ER during my rotation who presented with stridor and difficulty breathing. The ER attending and I were cautious as examination of the upper airway had to be carried out carefully in suspected cases of epiglottitis and use of a tongue blade was to be avoided. Lateral neck x-rays were not perfect, and we needed to have this child examined under anesthesia to make the accurate diagnosis under direct laryngoscopy. Fortunately, this revealed a normal epiglottis, and the child was not intubated to protect the airway. During my residency the use of a vaccine against invasive Haemophilus influenzae increased, resulting in a greater than 90% reduction in this illness, and for me, the last case of epiglottitis occurred prior to that during my internship. Although this remains in the differential of all airway disease, it is a vaccine-preventable disease.

I had a recent conversation with a patient and thought about our current dilemma with COVID-19. She had just lost her husband of over 50 years to a natural, non-COVID cause. I again confirmed that they were both vaccinated against COVID and were discussing the vaccine concerns of many unvaccinated Americans. Her generation’s vaccination rates against COVID-19 are the highest in this country. She was surprised by the attitudes of the unvaccinated compared to her generation’s response to controlling polio, a disease parents feared for its debilitating effects and high mortality in those most severely affected. After the development of this early vaccine under much less stringent criteria, children lined up in massive vaccine sites for a chance to protect themselves from this illness.

In 1994, polio was considered eradicated from the Western Hemisphere.

Her generation relied on medical experts and followed those recommendations. There were very few media outlets that created controversy simply to create controversy. Politics were always politics, but we did not weaponize health and infection control measures to create fear and uncertainty in the process, and there was more trust in the medical community.

Most of us in healthcare see things through a different lens than those trying to make decisions for themselves regarding vaccine use. Having these conversations with patients is difficult today, as there is so much to consider and changing attitudes and perceptions are often met with more resistance and people digging into their positions. The battle is less about infection control and more about getting everyone to come along at their own pace. Vaccine mandates will give this a push, but the burden of understanding still rests with the doctor patient relationship and the understanding we can provide.

Michael A. Adornetto, DO, MBA, FACOI
President
president@acoi.org
#ACOI2021: “This is the one not to miss!”

A One-on-One with ACOI Convention Chair, Robert T. Hasty, DO, FACOI

The last time the ACOI Annual Convention & Scientific Sessions was held in person was 2019. Only two years ago. According to Robert T. Hasty, DO, FACOI, Convention Chair, since that time, everything has changed in medicine.

That is what prompted the ACOI Convention Education Committee to land on the Convention theme: Medicine 3.0.

“As a result of COVID, we’re actually entering into a completely new era of medicine. Medicine 1.0 was the traditional medicine by William Osler (one of the four founders of Johns Hopkins Hospital); Medicine 2.0 was how medicine was changed as a result of the information age and the internet. Medicine 3.0 is all about addressing the post-COVID world.”

Dr. Hasty believes that COVID’s impact on medicine has been dramatic and has touched on everything from telehealth to the increasing scrutiny on evidence-based medicine. In addition, the controversial intersection of politics and public health, including the dialogue of what is and what is not true science, has contributed to the extra stress that physicians are shouldering.

“Over the last 18+ months, physicians have been facing unprecedented struggles at a time when their practices are impacted from lost revenue, and they are increasingly stretched from the demands of dealing with the pandemic. It is adversely affecting their resilience.” The 2021 ACOI Annual Convention & Scientific Sessions was built around all of these trends and realities.

“There’s no question that it’s more difficult to be a physician in 2021, emboldening us to remain steadfast in our promise to be there for our members as their go-to source for quality education. Our commitment remains the same this year as it has in years past—and will continue into the future.”

He said that is why this year’s Convention is so important —focusing on the future of the physician is an integral part of this year’s conference strategy. “One of the things I am looking forward to the most this year is our keynote speaker, Dr. Jen Caudle. She’s an incredible thought leader in medicine right now. Her perspective on how COVID is impacting physicians will be an important message for folks to hear. I’m very proud that we get to bring her message to our members!”

“As I look at the program and think about all of the experts we are bringing together to speak and educate our members at this year’s Convention, it is obvious to me that this is the one Convention not to be missed! I hope our members will register for the conference because they will not want to miss out on some of the things that we’re going to be learning!”

Register today for #ACOI2021

#ACOI2021 is tackling Medicine 3.0 with keynote speakers and sessions designed to get to the heart of this next era in medicine and to help osteopathic interns prepare for the future.

We’re not afraid of controversy. Medicine 3.0—this year’s #ACOI2021 theme—leaves no subject untouched in today’s volatile healthcare landscape.
Within a matter of weeks, across the nation schools will have opened their doors again and welcomed a new academic year. Just a few months ago there was hope that this fall would be different than last year and mostly free of the threat from COVID-19. However, America is experiencing a new surge partly due to a lull in vaccination uptake. Vaccination hesitancy is not unfamiliar territory for physicians. Physicians still receive pushback in certain cases when recommending proven childhood vaccines. It is not that hard to believe then, that COVID-19 vaccination rates have slowed down. With the Delta variant dominating, one would hope that we can increase our level of protection by getting vaccinated and achieving herd immunity. Yet this currently appears to be a challenging task. If we can identify factors contributing to vaccine hesitancy, then as a medical community, we can target the vulnerable in order to increase vaccination rates.

The US COVID-19 vaccination program began in December 2020. As of today 71.5% of people over 12 years of age have received at least one dose of the coronavirus vaccine. According to the most recent numbers, the percentage of people fully vaccinated was lower among Black and Hispanic persons (27.3% and 34.1%) than it was among White persons (34.9%). (CDC August 29, 2021). Vaccine coverage was lower in rural counties (38.9%) compared to urban counties (45.7%). (CDC May 2021).

Why is there a hesitation to be vaccinated? Risk perceptions were significantly associated with vaccine uptake. Hesitancy or lack of vaccine confidence, concerns about vaccine safety, political party preference, and potential adverse effects on fertility are some of the perceptions that affect vaccination uptake. Misinformation as a result of unregulated social media sites, lack of trust in institutions, low education, insecurity around employment, and residency in immigrant populations are also contributing factors. Also, there is a belief that there has been a continuous underrepresentation of minorities in healthcare research and vaccine trials. Long standing systemic racism, discrimination, and cultural insensitivity have led to vaccine hesitancy among minorities. The speed of vaccine development and frequently changing reports about side effects are also creating more suspicion and mistrust in some. The Tuskegee syphilis experiment is an example of history playing a role in some of the vaccination decisions made today. This was a study conducted by the United States public health service and the CDC. The study enrolled indigent African American males with syphilis who were promised free medical care as an incentive but never received it in an effort to study the natural course of untreated syphilis. Granted, since this study, multiple strides have been made to ensure research is carried out humanely and ethically. Yet events like this can fuel the distrust of the healthcare system.

According to one study, when it comes to rural residents, 86% say they trust their own doctor to provide reliable information about a COVID-19 vaccine. This is compared to FDA (68%), CDC (66%) and Dr. Fauci (59%). As representatives of the healthcare system, to overcome barriers, we need to acknowledge and address the historical injustices and ongoing inequities that drive distrust. Once this is achieved, we can work together with our patients to educate them about the COVID-19 virus and how the vaccine works to fight against it, while dispelling any misinformation they may have from social media and other sources. Vaccine safety needs to be addressed with transparency. The doctor-patient relationship, built on engaging our patients and understanding their cultural backgrounds while earning their trust, can facilitate a positive change in vaccination rates. As physicians, this is our opportunity to stop the spread of COVID-19. Let’s educate our patients, provide a listening ear, advocate for the vaccine, and end this pandemic together.
ACOI Healthcare Heroes: Dr. Leonard R. Hock
Working Every Day in the “Belly of the Beast” and Relentlessly Educating to Halt Vaccine Hesitancy
by Gina Kilker

When Leonard R. Hock, DO, MACOI, came out of retirement and went back to work in January, it wasn’t the demands of the pandemic that compelled him to do so. It was the pressure of being retired. “Retiring was stressful. I didn’t have a routine. When you try to force yourself to relax, it becomes anxiety-inducing. So I came back to work! The day I came back to work my life was better.”

He stands by that statement even today as he finds himself in the “belly of the beast,” knee deep in a new unrelenting surge of COVID-19 cases. The dangerous combination of the proliferating Delta variant and the large segment of the population who remain unvaccinated in Florida have been overwhelming the Orlando Health System where he has been working and treating COVID-19 patients since the beginning of the pandemic. The hospital now is about as busy as it was 13 months ago when COVID-19 was ravaging his state last summer.

The current surge began two months ago, and he says it is so severe that his hospital is 20% over capacity. To accommodate the demand, the hospital’s outpatient chest pain clinic is now a COVID unit. Similarly, a portion of the Emergency Department at the hospital has also been converted for COVID-19 patients.

Throughout his 40 years in healthcare, he has served as an intensivist, a geriatrician, a hospice physician, and a palliative care physician. In those roles, he has seen his share of burnout in his colleagues, driving some to switch specialties or quit healthcare altogether to pursue different careers. But this time he says he is witnessing something different.

“I have seen the exhaustion. We’re working long hours and extra shifts. There is a workforce shortage in all of health care and in the intensive care unit as well. But this is different than I’ve ever seen in all of my career.” The “something different” he is seeing? Anger.

One of those bouts of anger he witnessed firsthand was from a nurse who was taking care of a dying 22-year-old COVID patient. She agonized over the heartbreak she saw in the patient’s mother. “The nurse told me, ‘I’ve never been this angry! He could have taken the vaccine and he probably would have lived. Maybe he would have gotten COVID anyway. But I doubt it.’”

With his specialty in palliative care, he sees only the worst COVID-19 cases. In observing the stress level of his staff, he’s questioning whether those who refuse to get the vaccine should be permitted to inordinately burden the system. “We don’t judge anybody. We just take care of people the way they are despite the belief systems that they have. But I can feel the frustration when it would be so easy to not die of COVID.”

As the chairman of the Florida Medical Directors Association, his personal experiences treating individuals who refuse the vaccine is part of what is propelling him on his mission to do whatever he can to stop vaccine hesitancy. He has no hesitancy in communicating the importance of getting vaccinated. Dr. Hock has produced videos to distribute to organization members, and while some of his messages include unusual props and humor, he feels strongly about getting his point across any way he can.
For Dr. Hock, who was a regular TV guest in Kansas City on Fox 4 when he lived in the Midwest, speaking into the camera comes naturally. What is somewhat unnatural for him, however, is the conflict he is feeling about patient rights regarding vaccine choice.

“I take care of every patient every day and again, without judgment, but I’m starting to form strong opinions, not judgment, but opinions, about COVID and the vaccinations.” He recently spoke to the Florida Bioethics Networks at their annual meeting in Miami and sought advice from one of the philosopher ethicists about how far patient rights extend during a pandemic. According to Dr. Hock, the ethicist’s answer was swift, “He said no one has the right to do anything that could cause someone else to be sick.”

He is on board with that way of thinking, but as someone who has always respected individual autonomy when it comes to healthcare, he wonders how far society should go to mandate vaccines.

“I’m not much of a coercer. In palliative care, we just don’t coerce, but when I’m in the hospital and I see the whole hospital has become a COVID unit and much of the hospital has become an intensive care COVID unit, I’m thinking although they had the right not to choose the vaccine, do they now have the right to say, ‘I didn’t want a shot, but now I want everything that healthcare can give me!’ I’ll even risk making other people sick because I got sick and I’ll take advantage of the American benefit of health care, no matter what the cost. I’ll use the medications that could be available to someone else.

I’ll make the staff use the personal protective equipment. I’ll exhaust the nurses. I’ll make the therapist angry. I’ll probably have people quit healthcare because they can’t tolerate the decision that I, and so many others, made. So, is their ‘right-of-choice’ a right to make other people sick, to deplete resources, to exhaust the energy of the health care workers that professionally love them and want to cure them?”

Dr. Hock has heard the reasons why individuals don’t want the vaccine. He’s heard the fears that the MRNA vaccine will change their DNA, that they don’t trust the government, that no one has the right to tell them what to do and he’s even heard people express that they didn’t want the vaccine because they didn’t want a sore arm.

“In just the last week, I’ve had four young men in my care – ages 55, 52, 22, and 19. They didn’t want to take the vaccine because they were ‘tough guys.’ They were all strong men. Why should they take it? They’re just fine they said. They were anti-authority—especially the two younger ones. I heard ‘we’re not going to be told what to do.’ ‘The government’s not going to push us around.’ So, they had their reasons not to be vaccinated and all four men died.”

“These people that were so tough and so anti-authoritarian get to dig in and not take it, then as they are dying, their families beg us to give them the vaccine. It is heartbreaking for us—especially since all they needed to do was just take the vaccine six weeks ago.”

Dr. Hock was one of the first in the country to get the vaccine in December, 2020. He is proud that he hasn’t missed a day of work since. “I’ve been in practice over 40 years so I’m certainly not 55 anymore, but I’m healthy going into the ‘belly of the beast’ every day because I was vaccinated. How long will it last? I don’t know. Will it be lifelong immunity, or will I need to have a booster shot or a different shot next year? We’ll see. But, if needed, I will get vaccine when the true science, not the political science, directs me. I’m not going to live on the edge of my chair wondering when I’m going to need another shot. Life is for the living.”

**Editor’s Note:** Throughout this series of Healthcare Heroes stories published in this newsletter, our goal has been to reflect the realities and truths as seen through the eyes of our members. We’ve heard numerous stories of how our members are managing the stress of being at the epicenter of healthcare during an historic pandemic. We know there are likely many of you who can relate to the sincerity of this story as well as others we have featured. We invite you to share yours. Or, if sharing isn’t something you are comfortable with, we hope you can at least take solace in reading stories like Dr. Hock’s and knowing you are not alone. We are an organization that has been built on listening and support. Contact Susan Stacy at susan@acoi.org to share your story or to let us know how we can help.
Dear Members, Colleagues, and all those you influence,

This letter is a glimpse into my own experience and the impact of achieving personal wellbeing in your life. Thank you for asking me to share my story.

I used to spend my whole life planning for the future. In grade school, I focused on studying for the high school entrance exam; in high school, preparing for the SAT; in university, tailoring every fiber of my being on mastering the MCAT. Once enrolled in medical school, it was about getting high grades and performing well during rotations so that I could secure a sought-after internship/residency. Class rank was paramount. After training, my being was focused on securing the ideal job/career, advancing myself within the company while getting married, having children, purchasing a house, and starting to pay down my debt.

I worked an inhumane number of hours doing the above, always seeking perfection and trying to reach the next level, an ideal that had been emblazoned on me by my parents and my environment growing up. There was no time for me or my interests, nor time for anyone else.

Ironically, nobody asks me about my class rank or my exam scores. Nobody asks to see my degrees or credentials, but the one thing people do remember is how I make them feel.

I scorched through my teens, twenties, thirties, and most of myforties always worrying about the future at the expense of the present. I was caught fulfilling the needs of work/partners/colleagues, trying to be a good spouse and parent, while ignoring my happiness and needs. That led to years of personal neglect and burnout. Negativity predominated.

I carried the glass balls of friendship, health, and integrity, along with the rubber ball of work. I realized that when I dropped the work ball, it bounced up back into my face, but when I dropped one of the glass balls, they shattered on the ground. I did not like the person staring back in the mirror at the beginning and end of each day.

Thankfully, I had a true friend from training who watched me through my narrative. Although not immune himself, he was able to help me realize that I was spinning my wheels uncontrollably, watching several “dumpster fires” coalesce into one huge bonfire, making it impossible to douse. My wife has also been amazingly supportive and understanding, and I’ve appreciated her more than ever. It started me on my current path, one of self-compassion, forgiveness, awareness, curiosity, honesty, and vulnerability.

I value presence, listen to my gut, establish healthy boundaries, forge new connections, and try to keep the soul in soulmate. Mindfulness is my jam and I’ve learned to let go of the past, and not worry so much about the future.

Almost every day starts with gratitude. To borrow from the Serenity Prayer—“give me the peace to accept the things I cannot change, courage to change the things I can, wisdom to know the difference, living and enjoying one day at a time, so that I may be happy in this life and supremely happy forever.”

I am older and no longer feel immortal. My time is finite and things matter differently. My outlook is changing and I accept it. It is a journey ebbs and flows, and it doesn’t happen instantaneously. Old habits and thoughts sometimes rear their ugly heads, but I’ve gotten better at acknowledging them, connecting with my feelings, then choosing a different path. That gives me power over them. I’ve learned to wait for the limbic system flight or fight reactionary response to pass and allow my prefrontal cortex to activate to make better decisions.

I am proud and like the person staring back at me in the mirror now. I no longer work towards perfection, for that is impossible. My sleep is improved, my attitude is better. Physician, take care of thyself first, so that you may offer your best to those who seek your help.

Thank you for reading my story. I hope that it inspires you to reflect, improve self-awareness, self-expression, and lead to self-expansion. I’d also like to acknowledge and thank the rest of you out there who have had an influence on me throughout my life. I am glad to know and experience you.
As August comes to an end, the House and Senate are preparing for the fall push. At the front of the line for consideration will be the infrastructure package that was approved by the Senate. The Senate also approved a $3.5 trillion budget resolution that set the framework for the 2022 appropriation packages that must still be approved and sent to the President’s desk. The budget resolution also opens the door for the Senate to approve health care legislation by a simple majority, instead of the traditional filibuster-proof 60 votes. The budget resolution’s health care provisions address filling the Medicaid coverage gap, expanding Medicare, addressing health care provider shortages, pandemic preparedness, prescription drug pricing, and more. The ACOI will monitor these issues closely as Congress returns from its August recess.

**ACOI Joins in Opposition to VA National Standards of Practice**

The ACOI recently joined in opposition to the Department of Veteran Affairs’ efforts to develop National Standards of Practice for physicians and other health professionals through its Supremacy Project. These standards would be used to supersede the state scope of practice and licensure laws. In the comments submitted to the Secretary of Veterans Affairs, concern was raised that should the VA continue to move forward with these efforts, there will be implications well beyond the VA. The ACOI and others encourage the VA to initiate a meaningful process for the collection, dissemination, and inclusion of stakeholder input. The letter goes on to state, “Creating one standard for all physicians is impractical and not consistent with the practice of medicine.” With over 40 specialties and 87 subspecialties for physicians, the comments provided to the VA Secretary state, “Given this complexity, it would be nearly impossible for the VA to adequately capture the overall breadth of the practice of medicine and nuances among each physician specialty and subspecialty in one standard of practice...” In addition, the letter raises the concern that the National Standards of Practice drafted for non-physician providers (NPPs) may not accurately reflect the skills acquired through their education and training. You can access the full letter [here](#).

**Senate Approves Legislation to Fight Physician Burnout**

The Senate recently approved the “Dr. Lorna Breen Health Care Provider Protection Act.” The bipartisan legislation was developed to address the high rate of burnout and suicide among health care professionals. The ACOI partnered with the AOA and others in support of this important legislation, which would authorize grants for mental and behavioral health treatment for health care professionals. The legislation must be considered and approved by the House before it is sent to the President’s desk for enactment.

**Additional Funds Directed to Increase COVID-19 Vaccinations**

The Department of Health and Human Services (HHS) announced that it will provide $121 million in funding from the American Rescue Plan Act to increase COVID-19 vaccinations in underserved areas. The funds will be provided through the Health Resources and Services Administration (HRSA) to community-based organizations. This additional funding is on top of $125 million previously provided in response to an increase in the Delta variant.

**CMS Proposes Rule to Rescind Medicare Drug Pricing Rule**

The Centers for Medicare and Medicaid Services (CMS) announced a proposed rule to withdraw a final rule to align certain Medicare drug reimbursements with international prices. Under the final rule issued at the end of 2020, Medicare Part B was required to reimburse certain drugs on the lowest price in a group of “most favored nations.” An injunction was issued prior before the final rule took effect on January 1, 2021, based on the determination that the prior administration did not follow proper administrative procedure.

This important legislation would also make grant funds available to advance education and training on strategies to reduce and prevent burnout, suicide, and mental health conditions. The ACOI will continue to closely monitor this important legislation.

**Leadership**
Considering these and other concerns, CMS proposed withdrawing the rule in order to properly consider other issues that have been raised.

Washington Tidbits

From Counterfeiting to the President

Following the end of the Civil War, the nation faced yet another challenge that threatened its future—counterfeiting. Nearly one-third of all currency in circulation was believed to be counterfeit. To combat this, in 1865 a bureau was created as part of the Department of Treasury tasked to identify and stop this practice. Shortly thereafter, responsibilities were expanded to include “detecting persons perpetrating frauds against the government.” Focus was placed on the Ku Klux Klan, nonconforming distillers, smugglers, and others. Following the assassination of President William McKinley, the role of this organization forever changed. After a multitude of legislative action, the government agency is now tasked with not only protecting the nation’s financial institutions, but the nation’s leaders as well—the United States Secret Service has vastly expanded its responsibilities since its first founding in 1865!
It is that time of year again when the Centers for Medicare and Medicaid Services (CMS) issues a proposed rule that “announces and solicits public comments on proposed policy changes for Medicare payments under the Physician Fee Schedule (PFS) and other Medicare Part B issues” for implementation on or after January 1, 2022. This year’s proposal includes provisions that are both noteworthy and worth further review. Implementation of these changes could significantly impact your practice.

Changes to E&M services in 2021 impact other physician services codes such as:

- **Split Shared Services:** In recognition of the evolving role of non-physician practitioners (NPPs) and to clarify what must be met for payment, the following proposals have been made:
  - Defining that this type of E&M visit is provided in the facility setting for physicians and an NPP in the same group (clarifies existing policy).
  - The practitioner who provides the substantive portion of the visit, more than half of the total time spent, would be the one to bill for the visit (this is a change).
  - Split Shared visits can be on new and established patients for initial and subsequent visits (this is a change).
  - These visits could also be reported for prolonged services (this is a change).
  - A modifier would be required on the claim to help with program integrity.
  - Documentation in the medical record would identify the two individuals who performed the visit. The individual who performs the substantive portion of the visit needs to sign and date the medical record. (This is a possible change.)

- **Critical Care Services:** CMS proposed to refine their longstanding policies for critical care services with the following changes:
  - Allow critical care services to be furnished as split shared visits.
  - Allow critical care services to be furnished concurrently to the same patient on the same day by more than one practitioner who represents more than one specialty.
  - Provide that no other E/M visit can be billed for the same patient on the same date as a critical care service when the services are furnished by the same practitioner, or by practitioners in the same specialty and same group to account for overlapping resource costs.
  - Provide that critical care visits cannot be reported during the same time period as a procedure with a global surgical period.

**Continued**

Jill Young, CPC, CEDC, CIMC, is the principal of Young Medical Consulting, LLC, a company founded to meet the education and compliance needs of physicians and their staff. Jill has over 30 years of medical experience working in all areas of the medical practice.

youngmedconsult@gmail.com
Teaching Physician Services:

- With the changes to Office and other Outpatient E&M services, CMS is proposing to clarify that the time when the teaching physician was present can be included in determining the E&M level. Under the primary care exception specifically, only MDM would be used to select the visit level to guard against the possibility of inappropriate coding that reflects a resident’s inefficiencies rather than a measure of the time required to furnish the services. Under current rules, if a resident participates in a service furnished in a teaching setting, a teaching physician can bill for the service only if they are present for the key or critical portion of the service. Under the “primary care exception,” Medicare makes PFS payments in certain teaching hospital primary care centers for certain services furnished by a resident without the physical presence of a teaching physician.

The proposed changes listed above represent significant changes for practices. Specifically, I see the clarification of provider-based offices being able to utilize split shared services, but also the change to identify who provides the “substantive” portion of the work, which then allows the provider to be the billing provider. For many practices I have worked with, this represents a documentation challenge and a notable change in billing. As a result, bills submitted will identify the provider that performed the substantive portion of the work. This will also see potential revenue decreases if the NPP’s are the billing providers (which pays at 85% of physician fee schedule).

Again, all these provisions listed above are in the PROPOSED RULE that will not be finalized until mid-to late-November. The full 2022 proposal rule is available here.
I’m the patient.

The summer has come and it’s on its way out. We had company for 1.5 months straight. It all started with mom on July 5 and continued with different family until August 12. It was great to see them, but wow. I still had to work 12-hour days at the hospital and have vacationing people in my house. My home is in a state of flux getting repairs and painted, but they didn’t care.

What’s so osteopathic about this? I lost my fulcrum. My balance offset. Mind, body, spirit. Hours, food, sleep, emotions, all changed in the act of accommodation. Honestly, I found that the ‘set point’ and balance was at work. Ahhhhhhh...normal. But not for long.

August 12 arrives. All visitors gone. I am happy to return to a home setting with just my partner and dog. Peace. Quiet. Myalgias. Arthralgias. 1 day. 2 days. Chills, nausea, headache. Lyme? Anaplasmosis? Odd presentation of COVID-19?

Thank goodness I was not scheduled to work at the hospital. I would have never made it past my COVID-19 health screen to get into work!

I remember I went to bed on the second night seriously on the edge of going to work to be the patient. Great nurses, great doctors, I could rest. Instead, I went to express care the next morning. Negative COVID-19, negative tick panel. Doxy x 10 days. First 3 days at least 50% improvement. Exhausted from all my visitors. Exhausted with the stress of going through the process of Reappointment, Promotion and Tenure (RPT) at work. Exhausted.

Seven days later I see my internist (first time in 3 years) who is great at rheumatology. After inquiry and discussion of my daily life, stress, work, eating, and physical activity, he signs me up for my screening tests (which I successfully avoided for 3 years) and concludes that I have plantar fasciitis and too much stress. I’m not convinced. He sends me for lab work. Everything is normal: CBC, CMP, TSH, lipids, B12. The only thing I hear for prescription is exercise more, explore my surroundings more, go swimming, stretch, eat more vegetables, and take some time to play.

Most certainly take time to love.

I was surfacing through my own fog. I was awakening to my own disequilibrium.

So tonight, I hugged, kissed and spoiled my dog.

Tonight, I shared stories, laughed and loved my partner.

Tonight, I had an all-fresh garden vegetable salad and fruit picked from my yard for dinner.

I fell out of balance.

I knew it was coming.

I tried to keep my fulcrum/balance but gave too much of it away in those 6 weeks.

I’m coming around now. I’m feeling better.

I’m caring for myself more.

Exploring around me more.

Loving more.

Isn’t that what life is about anyway? Balance and love.
ACOI Online Learning Center

We understand the many hurdles you face as a busy practicing physician, resident, or student and want to help simplify things so you can focus on what is important to you and help you stay true to why you pursued medicine. The ACOI Online Learning Center (OLC) is your one-stop shop for the latest information in internal medicine and its subspecialties. You can find educational content available for both credit and non-credit. The OLC makes these resources available at your fingertips at a time and place most convenient to you. The OLC was recently updated to include lectures from the 2020 Annual Meeting and Scientific Sessions with more than 50 AOA 1-A credits available. The lectures are available à la carte or as a complete package saving your more than 50 percent! We understand the many challenges you face each day, staying abreast of your continuing medical education does not need to be one of them. You can access the OLC and all of its content here.

Online Learning Center Spotlight: Pixar Alum Discusses the Value of Story Telling

Matthew Luhn, a 20-year storytelling veteran, has spent his career evoking the emotions of his audience. Firmly believing that stories serve as much more than entertainment, Mr. Luhn said they can invoke emotion and, most importantly, stories can help a patient feel comfortable and open to listening to another’s viewpoint. For physicians, using metaphors and storytelling provide the ability to frame a procedure or a health goal in a way that transforms it from a sterile and, perhaps, frightening clinical scenario, to one that is not only more easily understood, but also relieves patients’ fears. Storytelling aligns with the goals of Principle-Centered Medicine™ and allows osteopathic internists to have better connections with patients and fosters relationship building while putting the heart back into medicine. Whether in business or in patient care, stories have proven to be an influential communications tool. This lecture is available for free on the Online Learning Center!

ACOI National Meetings

2021 Annual Convention & Scientific Sessions
October 27-30
Gaylord Palms & Convention Center, Orlando, FL
Hybrid Live/Virtual Meeting - Register now!

2022 Annual Convention & Scientific Sessions
October 19-23
Baltimore Marriott Waterfront Hotel, Baltimore, MD

2023 Annual Convention & Scientific Sessions
October 11-15
Tampa Marriott Waterside Hotel, Tampa, FL

2024 Annual Convention & Scientific Sessions
October 9-13
Kierland Resort, Phoenix, AZ

2021 Virtual Spring Meetings
These virtual meetings have been archived and can still be accessed through December 23, 2021. Register now!

Please note: It is an ACOI membership requirement that Active Members attend an ACOI-sponsored continuing education program at least once every three years.

Information on any meeting listed here may be obtained from ACOI Headquarters at 800 327-5183, or from our website at acoi.org.
Independent Internal Medicine Practice

Harry Pierce, DO, FACOI has an independent Internal Medicine practice within 15 minutes of downtown Seattle, Washington. He owns his building and is close to VM/CHI Saint Ann Hospital. If you have an interest in taking over his practice, he is willing to stay through 2022 to transition. Please contact him for more details at:

Harry Pierce, DO, FACOI
2909 10th Pl W
Seattle, WA 98119
harrypierce@me.com
206-890-0027

Hospital Level Care at Home

Our team at Sena Health is facilitating acute care in the home and collaborating with many physicians across the country. We are looking for like-minded individuals who are innovative, passionate, and team-focused to join us in making an impact advancing the aging-in-place philosophy and giving access to more convenient care.

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The ACOI Board of Director wishes to thank all ACOI members for their annual support for the College. The generous support from 75th Anniversary Circle members is of the utmost importance as we seek to maintain an osteopathic approach to internal medicine for future generations of patients.

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Thank You!
MISSION
The mission of ACOI is to promote high quality, distinctive osteopathic care of the adult.

VISION
ACOI seeks to be the organization that osteopathic internists think of first for education, information, representation and service to the profession.

VALUES
To accomplish its vision and mission, ACOI will base its decisions and actions on the following core values:

LEADERSHIP for the advancement of osteopathic medicine
EXCELLENCE in programs and services
INTEGRITY in decision-making and actions
PROFESSIONALISM in all interactions
SERVICE to meet member needs